State of Utah
Department of Human Resource Management

APPLICATION FOR FAMILY MEDICAL LEAVE

Employee Name: _____
Employee's Full Name

Agency/Dept: _____ Division: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Start Date of Anticipated Leave: _____ Expected Date of Return to Work: _____

Reason for Leave (Explain): _____

NOTE: A leave request based on an employee's serious health condition or the serious health condition of an employee's spouse, child, or parent must be accompanied by a verifying medical certification from a physician.

I understand that failure to return to work at the end of my leave period may be treated as a resignation unless an extension has been agreed upon and approved in writing by my employer. If I am able and elect not to return to work I will be required to reimburse health plan payments made by the State of Utah.

Employee's Signature: _____ Date: _____

This section to be completed by the Department

Supervisor Approval: _____ Date: _____

Agency HR Director Approval: _____ Date: _____